PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, March 30, 1999, 10:00 A.M., Massachusetts Department of Public Health, 250 Washington Street, Floor 2, Boston, Massachusetts. Present were: Dr. Howard K. Koh (Chairman), Dr. Clifford Askinazi (arrived late at approximately 10:45 Am.), Dr. Peter Connolly, Mr. Manthala George Jr., Mr. James Phelps, Mr. Albert Sherman, Ms. Janet Slemenda, Mr. Joseph Sneider; and Mr. Bertram Yaffe was absent. Also in attendance was Ms. Donna Levin, General Counsel.

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Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A 1/2. In addition, Dr. Koh announced that three additional presentations would be heard: 1) "Advance Data Births: 1997" by Bruce Cohen; 2) "Adolescent Births Supplement 1997" by Saul Franklin; and 3) City of Boston Infant Mortality Rates" by John Auerbach, Executive Director, City of Boston Health Commission. Dr. Koh also noted that item 2g (appointment of Russell Bullock) has been pulled from the docket because it does not require a vote.

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The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Bruce Cohen, Director Division of Research & Epidemiology; Bureau of Health Statistics, Research and Evaluation; Mr. Saul Franklin, Project Manager, Office of Statistics and Evaluation, Bureau of Family and Community Health; Dr. Deborah Klein-Walker, Assistant Commissioner, Bureau of Family and Community Health; Ms. Mayra Rodriguez-Howard, Director, Bureau of Substance Abuse Services; Ms. Joyce James, Director, Mr. Jere Page, Senior Analyst, Determination of Need Program; and Attorneys Kalina Vendetti, Tracy Miller and Carl Rosenfield, Deputy General Counsels, Office of the General Counsel.

RECORDS OF THE PUBLIC HEALTH COUNCIL MEETINGS OF JANUARY 26, 1999:

Records of the Public Health Council meetings of January 26, 1999 were presented to the Council. After consideration, upon motion made and duly seconded, it was voted (unanimously): That, records of the Public Health Council Meeting of January 26, 1999, copies of which had been sent to the Council Members for their prior consideration, be approved, in accordance with Massachusetts General Laws, Chapter 30A, Section 11A 1/2.

PERSONNEL ACTIONS:

In a letter dated March 9, 1999, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointment of Asha Garg, M.D. to the Provisional Consultant Medical Staff of Tewksbury Hospital. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Dr. Garg to the Provisional Consultant staff of Tewksbury Hospital be approved for a period of two years beginning March 1, 1999 to March 1, 2001:

APPOINTMENT	STATUS/SPECIALTY	MEDICAL LICENSE NO.
Asha Garg, M.D.	Provisional Consultant Staff	46368

In a letter dated February 8, 1999, John H. Britt, Executive Director, Linda C.Loney, M.D., Associate Medical Director, and Arthur M. Pappas, M.D., Chairman, Board of Trustees, Massachusetts Hospital School, recommended approval of the appointments and reappointments of medical practitioners and allied health professionals to the medical and dental staff of Massachusetts Hospital School, Canton. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees'qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director, Associate Medical Director, and Chairman, Board of Trustees of Mass. Hospital School, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the medical and dental staff of Massachusetts Hospital School be approved for the year 1998-2000:

APPOINTMENTS	STATUS/SPECIALTY
Sheila Bell, C.P.N.P.	Allied Health Professional/Pediatric Nurse Practitioner
Joseph G. Borer, M.D.	Provisional/Urology
Kathleen Connolly, M.S., R.N.C.	Allied Health Professional/Pediatrics
John T. Jones, Ph.D.	Allied Health Professional/Psychology
Karen Madden, M.S., R.N.C.	Allied Health Professional/Pediatrics

MaryJane O'Malley, M.S., R.N.C.	Allied Health Professional/Pediatrics

REAPPOINTMENTS	**STATUS/SPECIALTY**
Carlton M. Akins, M.D.	Active/Orthopedics
Anthony Atala, M.D.	Active/Urology
Frederick Ayers, M.D.	Courtesy/Orthopedics
Isabel M. Balmaseda, Acupuncturist	Allied Health Professional/Pain Management
Elizabeth D. Barnett, M.D.	Active/Infectious Diseases
Stuart B. Bauer, M.D.	Active/ Urology
John Bernado, M.D.	Active/Pulmonary Medicine
Benjamin E. Bierbaum, M.D.	Active/Orthopedics
Christine C. Campbell-Reardon, M.D.	Active/Pulmonary Medicine
David M. Center, M.D.	Active/Pulmonary Medicine
Henry H. Cho, M.D.	Active/Physiatry (Rehabilitation Medicine)
Ellen R. Cooper, M.D.	Active/Infectious Diseases
Thomas Cooper, M.D.	Active/Dermatology
David A. Diamond, M.D.	Active/Urology
John Emans, M.D.	Active/Orthopedics
Murray Feingold, M.D.	Courtesy/Genetics
Louisa Fertitta, M.S., R.N.C.	Allied Health Professional/Gynecology
John P. Ficarelli, D.M.D.	Active/Dentistry
Gerald S. Fine, D.D.S.	Active/Oral Surgery
Alejandro Flores, M.D.	Active/Gastroenterology
Geraldine C. Garcia-Rogers D.M.D.	Active/Reappointment
Lawrence A. Gray, M.D.	Active/Pediatrics
Steven W. Greer, M.D.	Consultant/Pediatrics
Sheela Gurbani, M.D.	Active/Reappointment
Jo-Ann Harris, M.D.	Active/Infectious Diseases
Timothy M. Hresko, M.D.	Active/Orthopedics
Carol Lee Hubbard, M.D.	Active/Pediatrics
James M. Kenny, M.D.	Active/Pulmonary Medicine
Frances J. Lagana, DPM	Active/Podiatry
Linda C. Loney, M.D.	Active/Pediatrics

David Levoy, M.D.	Active/Psychiatry
Peiman Mahdavi, D.M.D.	Active/Orthodontics
Joanne L. Mitchell, M.D.	Active//Pediatrics
William J. Morgan, M.D.	Active/Hand Surgery
Alan L. Morris, D.M.D.	Active/Periodontics
Nasser Nabi, M.D.	Active/Cardiology
Carolanne Oller-Chiang, Therapist	Allied Health Professional/Pain Management
Arthur M. Pappas, M.D.	Active/Orthopedics
Scott F. Petrie, M.D.	Active/Dentistry
Alan B. Retik, M.D.	Active/Urology
Aruna Sachdev, M.D.	Active/Rehabilitation Medicine
Arthur J. Schneider, M.D.	Active/Radiology
Cathy Stern, O.D.	Allied Health Professional/Optometry

In a letter dated March 10, 1999, Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Paul Stack to Program Manager V, (Director of Ancillary Services), Massachusetts Hospital School, Canton. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Paul Stack to Program Manager V (Director of Ancillary Services), at Massachusetts Hospital School be approved.

In a letter dated March 8, 1999, Robert D. Wakefield, Jr., Executive Director, Lemuel Shattuck Hospital, recommended approval of an initial appointment and reappointments of medical practitioners and allied health professionals to the medical staff of Lemuel Shattuck, Jamaica Plain. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees'qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the medical staff of Lemuel Shattuck Hospital be approved:

APPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Ethan Balk, M.D.	Consultant/Internal Medicine	77179
Barry Collet, DPM	Consultant/Podiatry	1489
Farhat Homsy, M.D.	Consultant/Surgery	45108

REAPPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Stephen Drewniak, M.D.	Active/Gastroenterology	43997
James Quirk, M,D.	Active/Internal Medicine	72941
Robin Reed, M.D.	Active/Internal Medicine	54662
Janice Rothschild, M.D.	Consultant/Surgery	57559
Suzanne Salamon, M.D.	Active/Internal Medicine	154943
Robert Schlesinger, M.D.	Consultant/Urology	32227
Maria Warth, M.D.	Endocrinology	53898
Stephen Wright, M.D.	Consultant/Gastroenterology	34464

In a letter dated March 10, 1999, Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Nunicata DePaul to Administrator V, (Director of Human Resources), Lemuel Shattuck Hospital, Jamaica Plain. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Nunicata DePaul to Administrator V (Director of Human Resources), at Lemuel Shattuck Hospital be approved.

In a letter dated March 10, 1999, Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Philip Wood to Program Manager VI, (Director of Mass. Health Assessment Partnership), Central Office, Boston. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Philip Wood to Program Manager VI (Director of Mass. Health Assessment Partnership) be approved.

In a letter dated March 12, 1999, Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Carlene Pavlos to Program Manager V, (Director of Violence Prevention), Central Office, Boston. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Carlene Pavlos to Program Manager V (Director of Violence Prevention) be approved.

STAFF PRESENTATIONS:

"Advance Data Births: 1997"

Dr. Bruce Cohen, Director, Research and Epidemiology, Bureau of Health Statistics, Research and Evaluation, presented the report "Advance Data Births 1997" to the Council. Some of the reports highlights follow:

- Compared to the US as a whole and examining trends over time, Massachusetts 1997 perinatal indicators look good. The Massachusetts infant mortality rate (IMR) is 25% lower than the US figure; the low birth weight rate is 7% lower than nationwide; the teen birth rate is 36% lower; and use of prenatal care in the first trimester is 2% higher than the US. Since 1988, the teen birth rate in Massachusetts had declined 11% and the IMR has decreased 30%.

- Overall, the infant mortality rate (IMR, deaths per 1,000 live births) is relatively stable and low, but there were increases from 1996 to 1997. Changes in reporting of extremely premature and low birth weight infants may have contributed substantially to this observed increase.

- Increases in low birthweight have occurred over the last several years. These are, inpart, due to increases in multiple births. Multiple births are not without risks to mothers and infants. We need to consider the impact of this change on planning and targeting services for high risk women and babies. Also, the general aging of birthing population increases low birthweight as well. In fact, the fastest growing birth rate in 1997 was for women age 40-44. These increases in both LBW and IMR need to be carefully monitored and followed to see whether they represent trends in specific populations or merely year-to-year fluctuation.

- Disparities in perinatal indicators persist across:

  - Ethnic groups
  - Educational levels
  - Communities

- The infant mortality rate for blacks is substantially higher than for whites, access to prenatal care is lower for blacks and Hispanics, and teen birth rates are higher for some minority populations. Older urban areas (such as Lawrence, Brockton, Holyoke, Springfield and Lowell) have issues about access to timely prenatal care, teen births, and low birth weight.

- New birth certificate data allow the department to track changes in smoking behavior for women who give birth. In 1997, among Massachusetts women who smoked prior to becoming pregnant, nearly 2/3 decreased the amount they smoked or quit during their pregnancies.

- Finally, we need to recognize the importance of the birth certificate data for surveillance, research, and program development such as newborn screening, high risk infant identification and immunization tracking. It is extremely important that all physicians, other medical professionals, and hospital administrators sustain their efforts to provide timely data of the highest quality.

No Vote/Information Only

"Adolescent Births Supplement 1997"

Mr. Saul Franklin, Project Manager, Office of Statistics and Evaluation, Bureau of Family and Community Health, presented the report "Adolescent Births Supplement 1997" to the Council. Some highlights follow:

- Overall, Massachusetts continues to have a low birth rate among women ages 15-19 years relative to most other states and the nation as a whole. However, some Massachusetts communities have teen birth rates that are higher than the national rate. Moreover, there are still disparities across race/Hispanic ethnicity subgroups in relation to low birthweight prevalence, adequacy of prenatal care and infant mortality. The data presented in this profile are intended to present information that will assist those planning programs, provide evaluators and researchers with reference measures, and assist policy makers in their efforts to address adolescent health issues.

- In 1997, 5,904 infants were born to women under age 20, 55 more births than the previous year. This was the first increase in eight years. Overall, since its peak in 1989, the number of births to teens has declined by 23.7%, whereas the number of births to all women in Massachusetts declined by 12.0%.

- The 1997 percentage of all Massachusetts births that were to women under age 20 was 7.4%. Massachusetts continued to have one of the lowest percentages in the nation and is well below the national 1997 percentage of 12.8%.

- The 1997 Massachusetts teen birth rate was 33.8 births per 1,000 women ages 15-19. The teen birth rate changed little from the previous year, increasing slightly from 32.6 births per 1,000 15-19 year old women. The 1997 teen birth rate has declined 5.8% since 1989, when it was at its highest point (35.9 per 1,000). The Massachusetts teen birth rate continued to be considerably lower than the national teen birth rate. The 1997 Massachusetts rate was 36.1% lower than the 1997 national rate of 52.9 per 1,000.

- The overall distribution of teen births (births to women under age 20) by mother's age has varied little in the past several years, with 18 to 19 year old women accounting for just over 60% of all teen births. In 1997, over one-third (35.7%) of all teen births were among 15-17 year olds, and 1.7% were among teens under age 15.

- In 1997, 2,865 (48.5%) of all teen births were to white non-Hispanic mothers; 1,807 (30.6%) were to Hispanic mothers; 794 (13.4%) were to black non-Hispanic mothers; 214 (3.6%) were to Asian mothers; and 205 (3.5%) were to mothers of other race/ethnic groups.

- Between 1992 and 1997, the proportion of teen births that were to white non-Hispanic women decreased overall from 53.1% to 48.5%. The proportion of births that were black non-Hispanic teens also showed a steady decline, from 15.8% to 13.4%. The proportions that were to Hispanic and Asian teen women increased during the same period from 26.0% to 30.6% for Hispanics and from 2.7% to 3.6% for Asians. The proportion of births to Hispanic and Asian women of all ages also increased during this period.

- The percentage of teen mothers whose prenatal care was supported through public funds was 68.8% virtually unchanged from 1996 (68.7%). In contrast, only 20.9% of women 20 and older had their prenatal care supported through public funds in 1997 (similar to the 1996 figure, 20.4%).

- Of all teen women giving birth in 1997, 90.4% were unmarried. The percentage of births to unmarried teens has been growing steadily since 1980 when it was 56.9%. This trend is reflected among births to women age 20 and older as well; the percentage of births to unmarried, non-teen women doubled from 10.7% in 1980 to 20.6% in 1997.

- In-hospital paternity acknowledgment among teens increased from 62.8% in 1996 to 66.0% in 1997, and from 67.1% to 71.3% among births to adult women. Since 1992, there has been a 44.7% increase in paternity acknowledgment among teen births.

- Among all unmarried teen births with acknowledged paternity, 56.8% of the fathers were age 20 and older, 42.1% were between ages 20 and 24, and 12.7% were over age 25.

- The overall percentage of low birthweight (LBW) births to teen mothers changed little from 1996 to 1997 (9.4% to 9.5%). In 1997, the occurrence of low birthweight (LBW) among births to teens (ages 12-19) continued to differ across race/Hispanic ethnicity groups, with white non-Hispanic teens having the lowest percentages of LBW (7.8%). The 1997 LBW percentage among births to black non-Hispanic teens were 12.6%, and 9.9% among births to Hispanics.

- In 1997, cesarean sections occurred less frequently among teen births (11.6%) than among births to women age 20 and older (20.4%).

- Infant mortality rates (the number of infant deaths per 1,000 births) overall have declined since 1991 for both teen births and births to older women. The decline from 1991-1996 in the infant mortality rate (IMR) among births to teens was slightly higher than the decline among births to older women (25.2% vs. 23.0% decline, respectively). This trend was consistent across each race/Hispanic ethnicity group except Asians, for whom the numbers of deaths were too small to make a meaningful comparison.

- The five Massachusetts communities with the highest teen birth rates in 1997 were Holyoke (94.9 births per 1,000 Holyoke women ages 15-19 years), Chelsea (93.9), Revere (93.2), Southbridge (91.7), and Springfield (82.3). Twenty-four out of the 27 communities with the greatest number of

teens births in 1997 were also among the top 26 in 1996.

- For the first time since Massachusetts teen birth rates have been reported, all of the top ranked cities/towns with the highest number of teen births had a teen birth rate below 100.

No Vote/Information Only

"Infant Mortality Rates for the City of Boston"

Mr. John Auerbach, Executive Director, City of Boston Health Commission, presented statistics for the City of Boston. Some highlights of his presentation follow:

- In 1997, there were about 7,800 births to Boston residents. That represents about 1.4% increase over 1996 in births and a reversal of a 6 year trend of declining Boston births. The distribution of those births across the different racial and ethnic groups in the city remains relatively unchanged with about a third of the births being white, a third black, and about 20% being Hispanic and 8% Asian-American.

- Birth to adolescents, age 15 to 19, accounted for about 10.5% of the 7,800 births in Boston in 1997. That is about the same percentage as 1996. This is the second year in a row that we have seen a percentage of births to adolescents that has been below 11%.

- There was a slight increase in the adequacy of prenatal care in Boston with a 2% increase in the adequacy of prenatal care for both whites and Latinos in the city. We continue to see a disturbing disparity in terms of adequacy of prenatal care for Black women in the city. 65% receive adequate prenatal care and that has not changed in 1997 from 1996.

- In 1997, the percentage of women who smoke during pregnancy was only 8% in 1997, down from 19% in 1990.

- In 1997, there were 66 Boston infant deaths, and that represents an increase of 12 deaths or 22% increase in the number of deaths when compared to 1996. Almost half of the deaths, (32) were black infants, 25 were white infants, 6 Hispanic and 3 Asian infants.

- The 1997 Boston infant mortality rate was 8.4 infant deaths per 1,000 live births. That is 20% higher than the infant mortality rate for Boston in 1996.

- The 1997 infant mortality rate for black infants was 29% higher than the infant mortality rate for black infants in 1996. The infant mortality rate of 9.5 deaths per 1,000 live births for white infants is actually a 19% increase over the 1990 infant mortality rate of 8. This represents a 42% increase over the 1996 infant mortality rate for whites and represents the highest infant mortality rate for

white residents of the city in the last ten years.

- The infant mortality rates for Hispanic infants dropped dramatically during 1997 although the numbers are small and fluctuate year to year.

- The gap between the infant mortality rate for white and black Boston residents is narrowing but unfortunately the narrowing of this gap in the more recent years has been due to the dramatic increase in white infant mortality rate, particularly this year."

- Most of the infant deaths occurred within the neonatal period (first 27 days of life). The percentage of low birth weight babies has increased from 8.8% of Boston births in 1996 to 9.2% in 1997, a 5% increase. Low birth weight babies are approximately 5 pounds and less.

- In 1997, multiple births made up 3.7% of all Boston births.

In summary, Mr. Auerbach said, "Overall, there was an increase in very low birth weight babies who were dying; an increase in the very early gestational age of babies dying; a concentration of deaths among the babies in the first 27 days of life, and we saw an increase in the number of deaths among multiple births. When we look at those four characteristics and we pair them with the information that we looked at earlier, which was the adequacy of prenatal care either remaining the same or improving slightly and some improvements in behavior, it would seem to indicate to us that we need to broaden our perspective to not only include a focus on preconceptual care for the woman and general healthcare for the woman, because we know that there are a number of indicators including the ones that are listed here that correlate with birth outcome. We also note that there is some increased risk factors from the health indicators that are listed there. For instance, we know that there is an increase in HIV prevalence among women. That has been a steady trend over the last few years in Boston. And therefore, we think that the focus needs to be, while continuing our examination of the prenatal care, also looking at this issue of what are the pre-existing conditions that women have in terms of their general health that may lead to a poor birth outcome."

Mr. Auerbach noted, "In 1997, the City of Boston lost more than 5 million dollars in Federal funding that was focused exclusively on women's health, prenatal and postpartum care, The Boston Healthy Start Initiative….And the loss of 5 million dollars in very targeted services to the population that we are looking at with the rise in infant mortality, we believe had an impact, an impact that extended beyond the actual 5 million dollars by having a ripple effect in these institutions where the loss of a grant for some of these agencies can affect their overall infrastructure, administrative capacity to function and may result in cuts in other areas as well. And this came at a time when there was an increased pressure on a number of these agencies financially because of the growth of managed care and cavitated reimbursement and the fact that they were seeing a number of high risk women and children but not being reimbursed for a lot of the services that needed to be provided."

The City of Boston has developed a five-point action plan:

1) The City of Boston, together with the State Health Department, implement a new program called "First Link". This program is intended as the referral and linking service to identify every single newborn in the City of Boston and link that newborn to appropriate services and support by providing a home visit and coordinated care.

2) Expand the focus of infant mortality prevention to the preconceptual health of women. The Public Health Commission will collaborate with the community health centers as well as the hospital outpatient facilities to insure that a comprehensive system of care for women includes access to primary care as well as family planning, substance abuse treatment, mental health services, domestic violence prevention, smoking cessation and social services. In the next few months conduct a needs assessment to identify gaps in those services and solicit resources to improve a linked system for care for women in the city.

3) Secure new funding from a variety of sources to address infant mortality in the city.

   a) Mayor Menino will be proposing in increase in the City's FY 2000 Budget.

   b) Solicit additional federal funding to support infant mortality reduction and petition the federal government to restore the cuts in the Boston Healthy Start Program

   c) Identify local resources that can be used to improve the system of care and services available for women of childbearing age. For example, The Boston Foundation has agreed to convene within the next 30 days a meeting of private funders to solicit their assistance and refocusing on infant mortality reduction in the City.

4) Reinstate an infant mortality case review by doing chart review and interviews to collect valuable information which will help target services -- asking questions such as did the mother use fertility drugs, or have substance abuse problems or her HIV status. U.Mass. Medical School, Boston University School of Public Health and the Harvard School of Public Health have volunteered to help with the interviewing.

5) Initiate series of meetings with the Division of Medical Assistance, the Division of Health Policy and Finance and other payers to try to increase reimbursement practices and policies that support the provision of comprehensive care for women. In particular, focus on reimbursement systems for outreach for case management, for domestic violence counseling, for substance abuse prevention, interpreter services, and health education.

In closing, Mr. Auerbach said, "I just want to say that the information on infant mortality in Boston is disturbing, and it calls for a serious, thoughtful and aggressive series of steps to intensify our focus on women's health including preconceptual health, on prenatal care, and on health and social services to babies and their families in the first year of life. We would look forward to working with the

Department of Public Health as well as the other partners that I have mentioned in attempting to dramatically reduce the infant mortality rates that we have seen this year."

Chairman Koh added, "…That is a very ambitious action plan that we would be delighted to support and hear updates from you."

No Vote/Information only

"Public Private Partnerships To Prevent Inhalant Abuse"

Mayra Rodriquez-Howard, Director, Bureau of Substance Abuse made introductory remarks, followed by Dr. Lisa McCoy, Manager, Massachusetts Inhalant Abuse Task Force. Ms. McCoy said, "Generally, when we are talking about inhalants, we are talking about for the most part hydrocarbon substances. You start with a petroleum crude oil, take it through a refining process, and out of that process comes a number of different products, fuels and solvents, aerosols and gases, as well as refrigerants. One of the things that we have been stressing in the campaign is that this is National Inhalant and Poison Awareness Month and we are really working to develop a stronger link between the fact that inhalants are poisons. They are not drugs which is a shift that we have been working with people to make across the state. Initially we collected as much data as possible when we first heard about these figures that Mayra was talking about, to try and tease out a picture of who is most at risk in our state for inhalant abuse. In general, we found that all youths, all types are in danger or are at risk of inhalant abuse. But at that point we were seeing the highest rate among 7th and 8th graders, males, and youths in towns with populations of less than 10,000, also among Caucasian males. In response we created the Breath Away Campaign which was our vehicle for getting information out to the rest of the state. To date we have trained over 1200 people across the state. We have developed materials in three different languages and developed a web site so that people not only here in Massachusetts can have access to this information, but across the country as well. We believe that the Breath Away Campaign has been effective. When we did another survey, the subsequent installment in 1996, we saw a drop of over 25% in the rates of inhalant abuse for 7th and 8th graders. That is the current rate. That is the number of youths that said they had used inhalants within the previous 30 days. We are still higher than the national average and we have seen a shift in who is using inhalants here in the state. We are seeing a leveling out of the rate between males and females. We are also seeing a shift to towns of say 50,000 to 90,000 in population. It is slightly larger towns now. Over the past year, we have been working to develop different environmental approaches to inhalant abuse prevention. We have worked with school systems. We have worked with retailers here in Massachusetts, the medical community and also worked to produce a community roundtable that was held in January. In fact, the roundtable was facilitated by Heather Kahn who works with WCBV TV as a medical health reporter. Forty people attended. Panelists included: Dr. Alan Woolf, Director of the Massachusetts Poison Control Center; and Jon Hurst, President of the Retailers Association of Massachusetts. In addition, in February of this year, we joined forces with the American Academy of Pediatrics to reach physicians across the state. To date, we have reached over 1300 different physicians…."

Dr. Alan Woolf, said in part, "…Why I am here today is because the Poison Control System is involved in counseling both the public and health professionals alike about poisonings occurring in the Commonwealth. Annually we receive over 40,000 poisoning exposure calls in the Commonwealth and another 20,000 information calls regarding poisonings that happen in our state…Among the top five non-pharmaceuticals we get called about are hydrocarbons and volatiles and inhalants. We get a lot of these calls around these poisonings but not many with regard to adolescents and there are several reasons for this that I would like to share with you. One is that adolescent inhalant abuse is insidious and it remains under-diagnosed. In some cases it is misdiagnosed. So if health professionals as well as parents don't know that this is involving their adolescents, they are not aware that this intoxication is going on and they are unlikely to call the Poison Control Center. A second problem is that this is a hidden diagnosis so that adolescents can function with this gateway substance that will lead to other substance abuse problems later on in their lives…a third problem is that it is difficult to diagnose. It is not an easy test in terms of sending off blood or urine to aspirate for hydrocarbons. It is unlikely to come to the attention of a healthcare professional….The type of injuries caused by inhalant abuse involve memory loss, problems with functioning socially and in school and in the family relationship, damage to the central nervous system, the heart, the liver, the kidney and other vital organs…"

Jon Hurst, President, Retailors'Association of MA addressed the Council on inhalant abuse. He said , "…I read a lot the materials that the Department passed on to us and I talked to my own three sons, between the ages of 10 and 13 years old and found out what they knew. It was remarkable that they knew a lot more than I did about inhalants being used. Yet, their education level wasn't at the same level as what they knew about other drugs, alcohol, tobacco and so forth. So we decided to get involved in the campaign. We put together a packet of information for our 1700 members, which are Mom and Pop corner convenience stores, independent pharmacies, autopart stores and national chains like Home Depot. We educated them on this and asked them to get involved especially during National Education Week….A number of companies jumped on this and helped us out. Home Depot participated and we have a representative of the company here with us today. A restaurant supply store informed us that teenagers were coming in and buying nitrous oxide cartridges. They couldn't figure out why until they received our information packet. From now on they will be getting a brochure instead of the nitrous oxide cartridges.

Chairman Koh noted, "Thank you to the four of you for raising awareness about a very important and under-diagnosed public health issue. And I want to thank all of you for developing this unique partnership that is part of our mission here as well. You have done that beautifully, and we look forward to hearing further updates from the four of you."

No vote/Information Only

DETERMINATION OF NEED:

COMPLIANCE MEMORANDUM: PREVIOUSLY APPROVED DON PROJECT NO. 2-3956 OF HEALTHALLIANCE HOSPITALS, INC. FOR TRANSFER OF OWNERSHIP AND ORIGINAL LICENSURE:

Ms. Joyce James, Determination of Need Program, made introductory remarks. Mr. Jere Page, Senior Analyst, Determination of Need Program, presented the progress report to the Council. He said "…We have reviewed these reports submitted by both HealthAlliance and the Northern Healthcare Coalition which is, a watchdog group that was formed about three years ago to make sure that adequate healthcare services were provided in the area that Health Alliance serves and you will hear from them later as well. There are eleven conditions in total that we are talking about…In consultation with other Department staff, staff has determined that HealthAlliance is in substantial compliance with seven of the eleven conditions that we are discussing here. The seven conditions involve statutory free care, emergency services at the Burbank Campus, financial investment in the Burbank Campus, governance, free care services, education and outreach and outpatient services at the Burbank Campus. Staff also finds that Health Alliance is in partial compliance with the remaining four conditions which involve regional emergency medical services, non emergency transportation, mental health services, and interpreter services…We believe that additional time is required to achieve full compliance with all these conditions. Therefore Health Alliance has agreed to return to the Council in June with a further update on compliance with these four conditions: that is the EMS Services, non-emergency transportation, mental health and interpreter services, as well as to provide further reports on emergency and other outpatient services at the Burbank Campus…."

Questions by the Council followed, whereby it was noted that the applicants free care declined due to the efforts by social service agencies to enroll people in MassHealth, i.e., Medicaid. In regard to the interpreter services condition, Mr. Page noted that the applicant still needs to hire a coordinator for language and interpreter services; provide a progress report to the Department on compliance with interpreter services; and train its staff more quickly. Mr. Page said he did not feel it was an intent on Health Alliance's part to delay these things on purpose but that the delay is due to their merger with UMass Memorial.

Mr. Augusto F. Grace, Vice President of Community Relations for HealthAlliance, addressed the Council. He said, "…We believe we are in substantial compliance with all of the conditions. We have tried to make progress in all of the conditions. Some of the conditions are rather complex and involve other hospitals, other providers, and federal and state agencies. There were four conditions that staff said were in partial compliance. One is locating an ambulance on the Burbank Campus and housing an ambulance in the garage there. The ambulance had been located at Burbank until the winter. The garage had not been built. Because the medications need to be kept at a certain temperature, the ambulance was moved off of the Burbank Campus. Now that the weather is warm again we will be moving that back to the Burbank Campus and we are looking at a facility that is on the Burbank Campus that already has a garage. We hope that by the time we come back in June we will be able to fully comply with that one. On the issue of transportation services, we were supposed to meet with the area providers to look at the transportation system. We met with the motor pool and the regional transit authority. I think there is a belief that we need to reach out to a few more providers and we are willing to do that. On interpreter services, I think the key point there was we were to hire a half time translator. We have done that. That translator is on board and works both as a translator and outreach services worker. There was also a requirement for us to form a committee to work with integrated groups. The

committee has been appointed by Health Alliance, the internal members, and we expect to be reaching out to the community members….Finally, the fourth condition was on inpatient psychiatric services and we are involved in negotiations with UMass. Memorial on psychiatric services on the Burbank Campus. There were a couple of conditions that the Northern Coalition wanted – one has to do with emergency services and the public education on emergency services. We think that is very important and we agree with that. Finally, the development on the Burbank campus of the cancer center and other outpatient services are being proposed again and we will report on that to you in June."

Attorney Clare McGorrian, Counsel for Northern Healthcare Coalition addressed the Council next. She said, "We were before the Council 11 months ago for the change of control from Health Alliance to UMass. Memorial Health Care. At that time, the Coalition was involved in carefully negotiating detailed conditions to the Determination of Need. Our goal in doing that was to make sure that adequate affordable healthcare was available to all residents in our service area. The Coalition's particular focus is on Fitchburg and the towns in the Northern tier and that is because the emergency services have been substantially reduced as well as many other services. …The concerns of the Coalition are primarily people, safety, quality of care and the survival of the Burbank Campus as a regional healthcare center for people in the area….The Coalition respectfully disagrees with the assessment of the DoN program that Health Alliance has substantially complied with all the conditions that were identified….There were several conditions that we felt were particularly move important than some of the conditions identified. Conditions #2 and #11, which we are happy to say that Health Alliance has voluntarily agreed to report back to the Council in three months, on emergency services as a whole and the outpatient services at Burbank which include the cancer center…We feel that a lot more needs to be done towards meeting these conditions…the Coalition is particularly concerned about a build up of waiting time at the Leominster Hospital emergency room and the building of Burbank as an outpatient center because we think it is critical. The Coalition has some continued concerns about governance. We think the process still needs to be more open and we hope to continue to build a more diverse board representation and we hope to continue meeting on that."

"In sum," Attorney McGorrian said, "we would like to recommend as we have in our comments and in our status reports, that there be a report back in three months on all of the conditions. We have agreement on six of them so there are only four more. It would be just as easy to report back on all of them. The Coalition feels that their involvement really has been critical in keeping Health Alliance on track. The Coalition has done a terrific job. They are representative of how a community coalition can keep a hospital system moving forward with all the other distractions that it has to deal with. Also DPH's continued oversight is critical. We look forward to working with Health Alliance further and with the DoN program and again, we ask the Council to vote for a report on all of the conditions in June."

Ms. Kathy Sicard testified to the Council. With regard to the conditions she noted that the Coalition was in basic agreement on conditions #1 (free care), #4 (capital contributions), #7 (free care expansion) and #10 (education and outreach). With respect to condition #1 she urged further outreach efforts to enroll residents in MassHealth. Ms. Sicard said, "There is an ongoing need to re-educate both the public and the physicians as to the services that are available at the Burbank Campus. Much must be

done to restore the confidence of both the public and the physicians in the utilization of the Burbank Campus." With regard to #3, Ms. Sicard stated, "We feel that due to the large volume of basic life support ambulances that are brought to the Leominster emergency room, EMS providers need further education regarding the type of patient care and services that are available at the Burbank satellite emergency room. This would hopefully relieve some of the stress that is being felt in the Leominster emergency room. There should be no further delay in the construction of an adequate bay for an ALS vehicle at the Burbank Campus, as called for in the conditions. Additional transport times due to not having this bay could conceivably result in a matter of life and death." With regard to condition #11, Ms. Sicard stated that the coalition has concerns about the availability of some of the present services, i.e., there is a 4-5 month wait for mammography services at the Burbank Campus; an inferior CAT scanner that physicians are reluctant to use; only one x-ray room to serve inpatient, emergency room patients and booked patients; fluoroscopy services have been discontinued and endoscopy services which had been available five days a week, are only available every third Monday. On mental health services, condition #9, Ms. Sicard said the Coalition looks forward to the update in June and urges Health Alliance to seek a meeting with Mass. Behavioral Health Partnership, as required by the condition. In closing, she said that the Coalition heard that a part-time interpreter is supposed to be hired, which will help alleviate the problems the Burbank Campus is having in this regard. The present interpreter, an employee on the Leominster campus with a position in the financial department, has problems being released to go to Burbank.

Ms. Mary Krapf read into the record some letters from members of the Fitchburg City Council. The letter from Paul Fontaine, Councillor-at-Large said, "…As an elected member of the Fitchburg community, I wish to convey my strongest possible desire to insure that all of our residents have continuing health care opportunities at the Burbank Hospital Campus in Fitchburg. As you take on a review of Health Alliance's performance relative to Burbank Hospital, I hope that recognition is given to the importance of this facility to Fitchburg residents and residents in bordering communities to the north of us. I ask that all conditions placed on the reorganization of Health Alliance be reviewed and enforced, included but not limited to the planned Campus center and the continuation of emergency room services at Burbank. Our region needs and deserves expanded services at the Fitchburg Campus. I appreciate all that you can do to insure that Fitchburg and the northern tier communities retain adequate health care services." Ms. Krapf read a letter from Herman Burke, Councillor-at-Large, "As a member of the Fitchburg City Council, I am very interested in monitoring the conditions of the Determination of Need around the license of University of Massachusetts and Health Alliance Hospital System. Fitchburg is a city of over 40,000 people who have been served by the Burbank and Leominster Hospitals for many years. My concern is that the conditions attached by the DoN will continue to be monitored as this system appears to be having problems, meeting the needs of the service area it covers. Just recently it has come to my attention that the emergency room at Leominster Hospital has had patients waiting unreasonable amounts of time for services. I feel that DPH needs to continue to monitor for the sake of public welfare. One full service emergency room is now left to cover both cities of Fitchburg and Leominster, which combined is over 80,000 people. This does not include the numerous surrounding towns that also have to utilize the emergency room. Therefore, I would appreciate your attention on the continuation of the monitoring of all the conditions attached to the DoN for the sake of the public interest I represent."

No Vote/Information Only

MISCELLANEOUS:

REQUEST ADOPTION OF THE MAGISTRATE'S RECOMMENDED DECISION AS THE FINAL DECISION OF THE DEPARTMENT IN THE MATTER OF PUBLIC HEALTH V. GREENLEAF NURSING HOME (PH-98-915):

Attorney Kalina Vendetti, R.N., Deputy General Counsel, Department of Public Health presented the Matter of Department of Public Health v. Greenleaf Nursing Home to the Council. She said, "This matter is brought to you to request that the Division of Administrative Law Appeal's decision granting the Department's motion to dismiss the matter before it be adopted as the final decision of the Department. The case came before the Division of Administrative Law Appeals (DALA) on the petition of the Greenleaf Nursing Home seeking to reverse the Department's Determination to recommend decertification of Greenleaf from the Medicaid program and its imposition of an admission freeze on the Greenleaf Nursing Home. This was based on surveys conducted at the Greenleaf Nursing Home through the Spring and into the Fall of 1998. In December of 1998, the Department determined that conditions at the Greenleaf Nursing Home had improved. It was in substantial compliance with the requirements for participation in the Medicaid program. It reversed its recommendation that the home be decertified to certified. It also lifted the admission freeze imposed on the Greenleaf Nursing Home. Greenleaf had however petitioned to the Division of Administrative Law Appeals seeking a decision to reverse the Department'' initial determination and also seeking damages for any losses incurred during the imposition of the admission freeze. The Department made a motion to DALA to dismiss Greenleaf's petition based on mootness because the decertification had been withdrawn and also based on the fact that DALA lacked authority to grant damages for the admission freeze. The Division issued a decision dismissing the case, granting the Department's motion in February and we now seek that the Council adopt it as the final decision for the Department of Public Health." It was noted that the facility is located in Salisbury, MA.

After consideration, upon motion made and duly seconded, it was voted unanimously to **Adopt the Magistrate's Decision as the Final Decision of the Department in the Matter of Department of Public Health v. Greenleaf Nursing Home**.

REQUEST ADOPTION OF THE MAGISTRATE'S RECOMMENDED DECISION AS THE FINAL DECISION OF THE DEPARTMENT IN THE MATTER OF EMERGENCY MEDICAL TECHNICIAN WESLEE S. SICARD (NO. PH-98-801):

Attorney Tracy Miller, Deputy General Counsel, Department of Public Health, presented the request for adoption of the Magistrate's Recommended Decision as the Final Decision of the Department of Public Health in the Matter of Emergency Medical Technician Weslee S. Sicard. Attorney Miller said in part,

"…The matter before you today is the Department of Public Health v. Weslee Sicard, and we are requesting that the Commissioner and the Public Health Council adopt the Magistrate's Final Decision in this matter. The Office of Emergency Medical Services certifies all EMTs in the Commonwealth and part of that responsibility is to suspend or revoke certification when there has been a violation of our regulations. That is the case here. An agency action was brought in October of 1998 against Weslee Sicard, who was a Basic EMT, to immediately suspend and then a request to permanently revoke his certification. That request was based on convictions for indecent assault and battery against a child under the age of 14. The grounds for that were two different regulations in the Office of Emergency Medical Services Regulations. That is any conviction related to the performance of an EMTs duties is grounds for revocation as well as any condition or action that endangers the public health and safety. Those are the grounds upon which the Department commenced this action. There was an immediate suspension. Mr. Sicard did appeal this decision to the Division of Administrative Law Appeals and the Department at that time made a motion for summary decision, which it had done in similar cases like this in the past. We were arguing that, based on the convictions alone which were undisputed, the revocation should take place. The Magistrate in the tentative decision, as you probably have seen, agreed with the Department's assessment that this was a conviction related to the performance of duties and it was also a conviction that endangered the public health and safety. I would add at this point that this decision and the Department's underlying policies that resulted in bringing this action are consistent with what the Department has done in the past with every other EMT for whom we have learned there was a conviction for sexual assault or any sex offense. We have gone back through our records, back to 1992. We have consistently asked for this sanction, and the Division of Administrative Law Appeals has consistently granted permanent revocation and the Public Health Council has consistently upheld those decisions in the past. I would add that in this instance, Mr. Sicard was only certified as an EMT for two months. He pleaded guilty to the offense while his application was pending at the Department, and it was only after that we learned through the Court system that his probation included a provision that said he would no longer work as an EMT that we immediately commenced this action. The Magistrate granted the Department's motion for a permanent revocation and we ask the Public Health Council to adopt the Magistrate's Decision as the Final Decision in this matter."

After consideration, upon motion made and duly seconded, it was voted (unanimously) to Adopt the Magistrate's Recommended Decision as the Final Decision of the Department in the Matter of Emergency Medical Technician Weslee S. Sicard, thereby revoking his EMT certification permanently.

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The meeting adjourned at 12:10 P.M.

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Howard K. Koh, M.D., M.P.H.
Chairman

LMH

MINUTES OF THE PUBLIC HEALTH COUNCIL

MEETING OF MARCH 30, 1999

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH